Department of Health

Board of Opticianry

Apprentice Optician Application

Department of Health
Florida Board of Opticianry
4052 Bald Cypress Way, #C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.floridasopticianry.gov
Email: MQA.Opticianry@flhealth.gov

Rule 64B12-16.003, F.A.C.
Form DH-MQA 1180, (Revised 1/14)

Apprentice Optician Application Instructions

There is no provision in Chapter 484, Part I, Florida Statutes, or Rule Chapter 64B12, F.A.C., to allow credit for any time worked prior to registration in the apprenticeship program.

Required Fee:
Submit a check or money order in the amount of $60.00 payable to the Department of Health. This registration fee is non-refundable and must be submitted with your application. Mail the completed application, fee, and supporting documentation to:

Board of Opticianry
P. O. BOX 6330
Tallahassee, FL 32314-6330

Any supporting documentation mailed separately from the application should be mailed to:

Board of Opticianry
4052 Bald Cypress Way, Bin C08
Tallahassee, FL 32399-3258

Pursuant to section 456.013(1)(a), Florida Statutes, an incomplete application shall expire one year after initial filing with the department.

The Board office will notify you within thirty days after receipt of your application and fee, informing you of any deficiencies in your application. A complete application consists of a completed application form and ALL required supporting documentation. A complete application will be approved or denied within 90 days of completion.

Address Change: If your address changes, you must provide written notification to the Board office. Include your full name, old address, new address, and whether this is your mailing address and/or your practice location address.

Name Change: If you have a legal name change, you must provide signed, written notification to the Board office. Include your full name as you applied, your new full name, and a photocopy of the applicable legal document. Your name cannot be changed without valid legal documentation.

Social Security Number: Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 456.013(12), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

Licensee Information on the Internet: When you become registered as an apprentice optician your name, license number and practice location address will be accessible through our Web site. The application asks for two addresses, a mailing address and a practice location address. All documents, including your license, will be sent to your mailing address. Your practice location address will be printed on your license and will show as your address of record on our Web site, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address. **NOTE:** Your practice location address must be a street address.

Documents in a Foreign Language: A certified translator, who is not related to the applicant, must translate any document that is in a language other than ENGLISH.

All licensees are responsible for knowing the laws and rules that regulate their profession. The laws in Chapter 484, Part I, Florida Statutes, are directly related to the profession of Opticianry, and Chapter 456, Florida Statutes, governs all health care professions licensed by the Department of Health. The rules in 4B12, Florida Administrative Code, govern the profession of Opticianry. The rules in 64B29, Florida Administrative Code, govern optical establishments. The laws and rules are accessible at the Opticianry Website at www.floridasopticianry.gov.

COMPLETING THE APPLICATION

Original forms with an original signature must be submitted; photocopies will not be accepted. Complete all forms by printing neatly in black ballpoint pen or typing all information. To eliminate mailing time and expedite your application, you may apply online at www.flhealthsource.com.

Section I. Applicant Profile Data: List your full legal name as it should appear on your license.

Section II. Education: Provide a photocopy of your high school diploma, transcript or equivalency certificate. If you attended a school of opticianry and want credit toward your apprenticeship hours, you must request an official transcript be sent directly to the Board office. A transcript will not be considered official if received from the applicant. Each credit hour earned at such school shall count as 86.67 apprenticeship hours. See rule 64B12-16.003(4), Florida Administrative Code (F.A.C.)

Section III: Sponsor Information: Provide the name, address, and license number of the individual who has agreed to be your primary sponsor. If you have a secondary sponsor, provide their name, address, and license number. A completed Sponsor Registration Form must be included with your application. Please note that all apprentices must complete training in filling, fitting, and adapting contact lenses. Failure of your sponsor to either mark "yes" that you will receive contact lens training or "no" that you will not receive contact lens training will delay the processing of your application. Your primary sponsor must sign this form and if you have a secondary sponsor, he or she must also sign the form.

- Approved sponsors include opticians licensed in Florida for at least one year, Florida licensed optometrists, Florida licensed allopathic physicians, and Florida licensed osteopathic physicians with a clear, active license. An approved sponsor may only sponsor a total of two apprentices at one time and an apprentice may have no more than two sponsors at one time.
- A licensed optician that is not board certified may not train an apprentice in filling contact lens prescriptions and fitting and adapting contact lenses. Training in contact lenses must be provided by a Florida board-certified optician, a Florida licensed optometrist, a Florida licensed allopathic physician, or a Florida licensed osteopathic physician. See Rule 64B12-16.003(6)(h), F.A.C.
- If your sponsor does not qualify to train you in contact lenses, you must find a sponsor who is qualified to train you or complete a Board approved course equivalent to 32 hours as a substitute for working experience with contact lenses.

Section IV. Applicant History-Professional: If you answer "yes" to any question(s) in this section you must provide the Board complete details.

Section V. Applicant History-General: If you answer "yes" to the history question in this section, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You **must** include a certified copy of the disposition(s).

Section VI. Applicant History – Pursuant to Section 456.0635, Florida Statutes:

IMPORTANT NOTICE: Effective July 1, 2012, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and **shall refuse** to admit a candidate for examination if the applicant:

1. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S., (relating to social and economic assistance), Chapter 817, F.S., (relating to fraudulent practices), Chapter 893, F.S., (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:
    - For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;
    - For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;
    - For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;

2. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues), unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;

3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;

4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;

5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

NOTE: This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

Section VII. Applicant Statement: Read this entire section then sign and date. Your original signature is required.

Section VIII. Social Security Number: Your Social Security number is required.

Section IX. Applicant History – Health: The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. If you have a history of serious, chronic, or recent mental health problems or addiction to drugs, you must submit a current mental health status report. Mental health status reports must come from a licensed mental health professional, with which you have no personal or professional relationship, wherein this professional opines that you are able to practice with reasonable skill and safety to patients or clients.

Florida Department of Health	**Apprentice Optician Application (2002)**

I. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	No. and Street.		Apt. No.
	City	State	Zip Code
* Practice Location Address	No. and Street		Apt. No.
	City	State	Zip Code

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Date of Birth: _____/_____/_____

Place of Birth: (City, State)

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?
❑YES ❑NO If "YES", list the name(s):

_____

_____

Home Telephone:	Business Telephone:	Fax Number:
Area Code ( )	Area Code ( )	Area Code ( )
E-Mail Address:		Sex: ❑ Male ❑ Female

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38295 (8/25/78). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.

RACE: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ Native American ❑ Other _____

II. EDUCATION

Name & Address of High School _____

Received: ❑Diploma ❑GED Date Completed: _____ _____

Name & Address of Optical School (if any) _____

III. SPONSOR INFORMATION

Primary Sponsor's Name:_____ Primary Sponsor's License No.:_____

❑Optician ❑Board Certified Optician ❑Optometrist ❑Allopathic Physician ❑Osteopathic Physician

Secondary Sponsor's Name: _____ Secondary Sponsor's License No.: _____

❑Optician ❑Board Certified Optician ❑Optometrist ❑Allopathic Physician ❑Osteopathic Physician

Your Practice Location Address will show on the Internet License Verification screen, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.

Please note that your practice location address must be a street address.

Rule 64B12-16.003, F.A.C.
Form DH-MQA 1180, (Revised 1/14)

IV. APPLICANT HISTORY – PROFESSIONAL

A.	Have you ever been denied licensure for Opticianry or any health-related profession or the renewal thereof in any state?	❑ YES	❑ NO
B.	Have you ever been denied the right to take an Opticianry licensure examination?	❑ YES	❑ NO
C.	Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	❑ YES	❑ NO
D.	Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	❑ YES	❑ NO
E.	Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency?	❑ YES	❑ NO
F.	Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:		
	1. Acts of dishonesty, fraud, or deceit	1.❑YES	❑NO
	2. Lying on a resume or misrepresentation	2.❑YES	❑NO
	3. Academic misconduct, including acts such as cheating or plagiarism	3.❑YES	❑NO
	4. Theft	4.❑YES	❑NO
	5. Sexual harassment	5.❑YES	❑NO

If you answered "YES" to any question in Section 4, you must provide the Board complete details.

V. APPLICANT HISTORY – GENERAL

A.	Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any crime in any jurisdiction, other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You **must** include a certified copy of the court records/dispositions.	❑ YES	❑ NO

VI. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation. Supporting documentation includes court dispositions or agency orders where applicable.

1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to # 2.)	❑ YES ❑ NO
a.	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?	❑ YES ❑ NO
b.	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	❑ YES ❑ NO
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	❑ YES ❑ NO
d.	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	❑ YES ❑ NO
2.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	❑ YES ❑ NO
a.	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	❑ YES ❑ NO
3.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)	❑ YES ❑ NO
a.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑ YES ❑ NO
4.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)	❑ YES ❑ NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑ YES ❑ NO
b.	Did the termination occur at least 20 years before the date of this application?	❑ YES ❑ NO
5.	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	❑ YES ❑ NO
6.	If "yes" to any of the questions 1 through 5 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? (If "yes", please provide official documentation verifying your enrollment status.)	❑ YES ❑ NO

VII. APPLICANT STATEMENT

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by s. 456.072, F.S., and 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby state that my sponsor and I have reviewed, together, Chapter 484, Part I, Florida Statutes (F.S.), and Chapter 64B12, Florida Administrative Code (F.A.C.), and specifically Rule Chapter 64B12-16, F.A.C.. I fully understand my responsibilities to my sponsor, the Board of Opticianry and the Department of Health, and the limitations of being registered in the apprenticeship program herein designated. I understand that it is my responsibility to keep informed of any changes to Chapter 484, Part I, F.S., and 64B12, F.A.C.

I understand that pursuant to s. 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

I understand that pursuant to Rule 64B12-16.003(4)(a), F.A.C., I am required to complete a two-hour Apprentice/Sponsor Orientation Course within one year of registration in the apprenticeship program. I have also informed my sponsor(s) that if they attend a two-hour Apprenticeship/Sponsor Orientation Course, the course will count toward either the elective or the laws and rules continuing education requirement for renewal of their optician license.

_____ _____

Applicant's Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health

Board of Opticianry

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: _____

Last **First** **Middle**

VIII. SOCIAL SECURITY NUMBER: _____

IX. APPLICANT HISTORY – HEALTH

If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

A.	In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B.	In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

Rule 64B12-16.003, F.A.C.
Form DH-MQA 1180, (Revised 1/14)

BOARD OF OPTICIANRY
SPONSOR REGISTRATION FORM

Print clearly in black ballpoint pen or type all information.

APPRENTICE INFORMATION

Apprentice Full Name: _____

Number of hours this apprentice will work per week under direct supervision of a sponsor: _____

PRIMARY SPONSOR GENERAL INFORMATION (Signature required below)

Sponsor Name _____ Business Name _____

Address/City/State/Zip _____

Telephone Number: ( ) _____ FAX ( ) _____

Primary Sponsor's License Number _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the primary sponsor?
☐**Yes** ☐**No [One of these boxes must be checked.]**

SECONDARY SPONSOR GENERAL INFORMATION (if applicable)

Secondary Sponsor Name_____ Business Name _____

Address/City/State/Zip_____

Telephone Number ( ) _____ FAX ( ) _____

Secondary Sponsor's License Number _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the secondary sponsor?
☐**Yes** ☐**No [If this section is completed, one of these boxes must be checked.]**

I state that I do dispense eyewear and maintain all of the equipment required by Rule 64B12-10.007, F.A.C., on the same premises where the apprentice works. I further state that my apprentice and I have reviewed, **together**, Chapter 484, Part I, Florida Statutes, and Rule Chapter 64B12-16, Florida Administrative Code. I declare that I fully understand my responsibilities to my apprentice and to the Board of Opticianry and the Department of Health, as a properly registered sponsor of an apprentice registered in the Opticianry apprenticeship program.

_____ _____

Signature of Primary Sponsor Signature of Secondary Sponsor (if applicable)

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